with no or mild pain during the follow-up period was obtained by pregabalin (59.6%;CI95% 59.0%–60.2%); followed by gabapentin (49.2%; CI95% 48.7%–49.7%); amitriptyline (47.6%; CI95% 47.1%–48.1%) and carbamazepine (34.4%; CI95% 34.1%–34.8%). The annual expected mean costs per patient were US$3001.4 (CI95% US$2956.4–US$3046.3); US$4,707.7 (CI95% US$4689.9–US$4723.6); US$2814.4 (CI95% US$2783.4–US$2845.5) and US$3701.9 (CI95% US$3687.2–US$3716.6); respectively following the order above. The ICER's of pregabalin vs. carbamazepine (baseline), gabapentin and amitriptyline were -US$700.5 (CI95% -US$670.4:-US$730.7), -US$1706.4 (CI95% -US$1677.3:-US$1733.4) and US$186.9 (CI95% US$173.1–US$200.8); respectively. Using acceptability curves (WTP US$5000–US$50,000), pregabalin showed a probability between 90–99% to be the treatment most cost-effective. **CONCLUSION:** In Mexico, pregabalin showed to be a cost-saving therapy when is compared with carbamazepine and gabapentin; and cost-effective vs. amitriptyline in the management of neuropathic pain.

DB3

REAL-WORLD ANALYSIS OF PERCENT OF PATIENTS WITH TYPE 2 DIABETES ACHIEVING GLYCEMIC GOAL WITH INSULIN GLARGINE

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OBJECTIVE: The primary aim of type 2 diabetes (T2D) therapy is helping patients achieve glycemic goals (A1C < 7%) as recommended by the ADA. In the recent randomized controlled trials 4-T and INITIATE, patients treated with basal insulin alone achieved goal 28% and 40% of the time, respectively, despite progressive insulin titration. In this retrospective cohort study using a large, US commercial health plan claims database, we describe the clinical effectiveness of newly-prescribed basal insulin glargine (IG) in insulin-naive patients. **METHODS:** A total of 13,154 insulin-naïve (not prescribed insulin in previous 6 mo) patients were identified with a new prescription claim for IG between January 1, 2004 and June 30, 2006, ≥6 mo of pre-index eligibility (first claim = index date), ≥12 mo of post-index eligibility, and ≥18 y old. **RESULTS:** From this cohort, 7730 (59%) patients had no other insulin claims other than IG in the entire post-index period. All patients with baseline (100 d pre-index) and post-index (60–365 d) A1C data available and baseline A1C≥7.0% were analyzed (n = 313; mean baseline A1C (±SD) = 9.8 ± 2.1%). Mean (±SD) age was 52 ± 8 y (41% female; 3%≥65 y). In this cohort of patients who did not add any additional insulin (n = 313), 27% achieved A1C < 7% in the post-index period (mean [min,max] time index to post-index A1C = 238 d [63,365]). Mean (±SD) post-index A1C was 8.2 ± 1.9%. **CONCLUSION:** In this real-world analysis of patients initiated on IG, the percentage of patients achieving A1C < 7.0% and mean post-index A1C indicate that most patients do not achieve recommended glycemic targets—results which mirror controlled clinical studies. In addition, more than half of patients initiating IG did not supplement with additional insulin therapy over the course of the first year of therapy, despite not reaching glycemic goals. Because the contribution of post-prandial glucose to A1C increases as A1C approaches goal, agents targeting fasting glucose alone, like IG, may be insufficient in helping patients with T2D achieve glycemic goals.

DB4

RETROSPECTIVE STUDY OF TYPE 2 DIABETES MELLITUS (T2DM) PATIENTS NOT OPTIMALLY CONTROLLED BY METFORMIN MONOTHERAPY

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OBJECTIVE: The American Diabetes Association (ADA) recommends metformin as first line treatment for T2DM. As diabetes is a progressive disease, patients will ultimately need additional therapies to reach glycemic goals. Little information has been published that describes what happens to patients not optimally controlled on metformin monotherapy in the real world. We analyzed monitoring, treatments and outcomes for such patients using the PHARMetrics® linked laboratory database. **METHODS:** An algorithm based on ICD-9 codes and laboratory test values identified 1901 T2DM patients who failed metformin monotherapy between 2000 and 2006. The index date was defined as the first Hba1c test greater than the ADA recommended goal of 7%, after at least 6 months metformin monotherapy. The pre-period was defined as two years prior to the index date. The follow-up period was defined as 12 months after the index date. Other laboratory test values were obtained during a +/–30-day window of the index date. Micro- and macrovascular diabetes-related complications were identified using ICD-9 codes during the pre-period. Subsequent glucose control and first therapy change in the 3 to 12 months of the follow-up period were also analyzed. **RESULTS:** A total of 48.5% of the sample was male. Mean age was 57.9 (±11). The prevalence of diabetic-related complications were as follows: retinopathy (12.64%); neuropathy (12.13%); nephropathy (2.67%); myocardial infarction (1.31%); stroke (2.82%) and ischemic heart disease (12.99%). In the follow-up period, 76.5% of patients had an Hba1c test and only 24.7% were at goal. Only 33% changed therapy: 19% added on sulfonylurea; 5% switched to a fixed-dose combination product and 4% added or switched to thiazolidinedione. Overall, the average time from failure until therapy change was 256.0 days (±73.1). **CONCLUSION:** These results indicate considerable unmet medical need in treating T2DM. Glycemic control would have likely been better with additional pharmaceutical utilization.

DRUG USE RESEARCH I

DU1

DEMOGRAPHIC RISK FACTORS FOR STROKE RELATED AMBULATORY CARE UTILIZATION: ANALYSIS OF UNITED STATES NATIONAL DATA 2000–2005

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OBJECTIVE: To assess age, racial, and regional differences in utilization of physician, hospital outpatient and emergency department services related to stroke over the past six years. **METHODS:** This study was a retrospective analysis of the National Ambulatory Medical Care Survey (NAMCS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS) from 2000–C2005. Ischemic stroke related visits in persons aged ≥45 years were identified using diagnosis codes (ICD 9 CM) 433.1x, 434.xx, and 436.xx. Visits per/1000 persons were calculated using United States population estimates. With logistic regression, we adjusted associations between stroke-related visits and age, race, and region (Northeast, Midwest, West, and South), for sex, stroke risk factors, insurance type, and survey year. **RESULTS:** From 2000 to 2005, stroke-related ambulatory care visits increased significantly from 8.3/1000 persons to 16.1/1000 persons (P Trend=<0.0001)–Crepresenting a 195% rise in stroke